Health History for Athletics

Student Name:	DOB
Sport:	Age
Grade ☐ 7 ☐ 8	Limitations: ☐ NO ☐ YES
Date form completed:	Date of last Health Exam:
Parent Email:	Parent Phone:

MUST be completed and signed by Parent/Guardian - Give details to any YES answers on the last page.

DOES OR HAS YOUR CHILD		
GENERAL HEALTH	**NO**	**YES**
Ever been restricted by a health care provider from sports participation for any reason?	☐	☐
Ever had surgery?	☐	☐
Ever spent the night in a hospital?	☐	☐
Been diagnosed with mononucleosis within the last month?	☐	☐
Have only one functioning kidney?	☐	☐
Have a bleeding disorder?	☐	☐
Have any problems with hearing or have congenital deafness?	☐	☐
Have any problems with vision or only have vision in one eye?	☐	☐
Have an ongoing medical condition?	☐	☐
If yes, check all that apply: ☐ Asthma ☐ Diabetes ☐ Seizures ☐ Sickle cell trait or disease ☐ Other:		
Have Allergies?	☐	☐
If yes, check all that apply ☐ Food ☐ Insect Bite ☐ Latex ☐ Medicine ☐ Pollen ☐ Other:		
Ever had anaphylaxis?	☐	☐
Carry an epinephrine auto-injector?	☐	☐
BRAIN/HEAD INJURY HISTORY	**NO**	**YES**
Ever had a hit to the head that caused headache, dizziness, nausea, confusion, or been told they had a concussion?	☐	☐
Receive treatment for a seizure disorder or epilepsy?	☐	☐
Ever had headaches with exercise?	☐	☐
Ever had migraines?	☐	☐

DOES OR HAS YOUR CHILD		
BREATHING	**NO**	**YES**
Ever complained of getting extremely tired or short of breath during exercise?	☐	☐
Use or carry an inhaler or nebulizer?	☐	☐
Wheeze or cough frequently during or after exercise?	☐	☐
Ever been told by a health care provider they have asthma or exercise-induced asthma?	☐	☐
DEVICES / ACCOMMODATIONS	**NO**	**YES**
Use a brace, orthotic, or another device?	☐	☐
Have any special devices or prostheses (insulin pump, glucose sensor, ostomy bag, etc.)?	☐	☐
Wear protective eyewear, such as goggles or a face shield?	☐	☐
Wear a hearing aid or cochlear implant?	☐	☐
Let the coach/school nurse know of any device used. Not required for contact lenses or eyeglasses.		
DIGESTIVE (GI) HEALTH	**NO**	**YES**
Have stomach or other GI problems?	☐	☐
Ever had an eating disorder?	☐	☐
Have a special diet or need to avoid certain foods?	☐	☐
Are there any concerns about your child's weight?	☐	☐
INJURY HISTORY	**NO**	**YES**
Ever been unable to move their arms or legs or had tingling, numbness, or weakness after being hit or falling?	☐	☐
Ever had an injury, pain, or swelling of a joint that caused them to miss practice or a game?	☐	☐
Have a bone, muscle, or joint that bothers them?	☐	☐
Have joints that become painful, swollen, warm, or red with use?	☐	☐
Ever been diagnosed with a stress fracture?	☐	☐

Student Name:		DOB:	

DOES OR HAS YOUR CHILD		
HEART HEALTH	**NO**	**Yes**
Ever complained of:		
Ever had a test by a health care provider for their heart (e.g., EKG, echocardiogram, stress test)?	☐	☐
Lightheadedness, dizziness or fainting, during or after exercise or in response to loud noise?	☐	☐
Chest pain, tightness, pressure or shortness of breath after exercise?	☐	☐
Fluttering in the chest, skipped heartbeats, heart racing?	☐	☐

DOES OR HAS YOUR CHILD		
Ever been told by a health care provider	No	Yes
They have or had a heart or blood vessel problem?	☐	☐

If yes, check all that apply:

- ☐ Chest Tightness, Pressure/Pain
- ☐ High or Low Blood Pressure
- ☐ High Cholesterol
- ☐ New fast or slow heart rate
- ☐ Has a pacemaker
- ☐ Previous testing for heart condition
- ☐ Has implanted cardiac defibrillator (ICD)
- ☐ Heart infection
- ☐ Heart Murmur
- ☐ Kawasaki Disease
- ☐ Other_____

DOES OR HAS YOUR CHILD		
FEMALES ONLY	**NO**	**YES**
Have regular periods?	☐	☐
MALES ONLY	**NO**	**YES**
Have only one testicle?	☐	☐
Have groin pain or a bulge, or a hernia?	☐	☐
SKIN HEALTH	**NO**	**YES**
Currently have any rashes, pressure sores, or other skin problems?	☐	☐
Ever had a herpes or MRSA skin infection?	☐	☐
COVID-19 INFORMATION	**NO**	**Yes**
Has your child ever tested positive for COVID-19?	☐	☐
If **NO, STOP.** Go to Family Heart Health History. If **YES,** answer questions below:		
Date of positive COVID test:		
Was your child symptomatic?	☐	☐
Did your child see a health care provider for their COVID-19 symptoms?	☐	☐
Was your child hospitalized for COVID?	☐	☐
Was your child diagnosed with Multisystem Inflammatory Syndrome (MISC)?	☐	☐

FAMILY HEART HEALTH HISTORY

A relative has/had any of the following:

Check all that apply:

- ☐ Enlarged Heart/ Hypertrophic Cardiomyopathy/ Dilated Cardiomyopathy
- ☐ Arrhythmogenic Right Ventricular Cardiomyopathy?
- ☐ Heart rhythm problems: long or short QT interval?
- ☐ Brugada Syndrome?
- ☐ Catecholaminergic Ventricular Tachycardia?
- ☐ Marfan Syndrome (aortic rupture)?
- ☐ Heart attack at age 50 or younger?
- ☐ Pacemaker or implanted cardiac defibrillator (ICD)?

A family history of:

- ☐ Known heart abnormalities or sudden death before age 50?
- ☐ Structural heart abnormality, repaired or unrepaired?
- ☐ Unexplained fainting, seizures, drowning, near drowning, or car accident before age 50?
- ☐ Disability from heart disease in a close relative?

- ☐ Previously restricted from participation in sports or physical activity
- ☐ Cleared from restriction by physician, nurse practitioner or physician's assistant. Date cleared: _____

Parent/Guardian Signature: _____ Date: _____

Student Name:		DOB:	

If you answered **YES** to any questions give details. Sign and date below.	
Parent/Guardian Signature:	Date: